Welcome

Paul Jarris, MD, MBA, Executive Director, ASTHO
Creating a Health In All Policies Approach

**Triple Aim of Health Equity**

- Implement a Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future

- Implement Health in All Policies
- Strengthen Community Capacity
- Expand Understanding of Health
Systems Approach for IPP LARC

Training and Tools
- Policies and Procedures
- Coding
- Billing
- Stocking & Supply
- Evaluation & QI
- Service Location
- Labor & Delivery

- Prenatal
- Insurance
Why ASTHO?

- ASTHO represents: U.S., U.S. Territories and freely associated states, and D.C. public health agencies

- Track, evaluate, provide TA, and advise on the impact and formation of public or private health policy

- Members, the chief health officials of these jurisdictions:
  - Convene governmental and nongovernmental agencies
  - Engage clinical and community partners
  - Leverage and link data to collaborate with public and private payers to drive payment policy reforms
  - Raise visibility among a broader community of policymakers, funders
Introductions

Lisa Waddell, MD, MPH, Chief Program Officer, Community Health and Prevention, ASTHO
Introductions

- Cohort 1 and 2 States
- Association of State and Territorial Health Officials (ASTHO)
- Centers for Disease Control and Prevention (CDC)
- Partners
Meeting Goal

This learning community will focus on the implementation aspects of LARC immediately postpartum (IPP) policy changes in states in order to identify technical assistance (TA) needs and promising practices to assist current and future states as they work to advance access to LARC.
Meeting Objectives

- Launch LARC IPP Learning Community Year 2, creating an opportunity for multi-disciplinary state teams to identify priority action steps and outcomes for the project year.

- Improve the capacity of states to successfully implement LARC IPP by facilitating state-to-state sharing of promising strategies and common challenges.
Meeting Objectives, Continued

- Highlight Cohort 1 lessons learned and goals for the future
- Discuss Cohort 2 policies, progress, and technical assistance needs
- Examine progress on the 8 domains of the LARC Learning Community and discuss priorities.
# Agenda Review: October 19th, 2015

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>10:35am</td>
<td>Overview</td>
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<tr>
<td>11:30am</td>
<td>Cohort 2 Presentations</td>
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<tr>
<td>12:30pm</td>
<td>Lunch: Peer Group Discussion</td>
</tr>
<tr>
<td>1:45pm</td>
<td>Cohort 2 Presentations</td>
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<tr>
<td>2:30pm</td>
<td>Peer Group Discussions</td>
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<td>3:15pm</td>
<td>Wellness Break</td>
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<td>3:30pm</td>
<td>State Team Time</td>
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<td>4:30pm</td>
<td>Facilitated Discussion</td>
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<tr>
<td>5:30pm</td>
<td>Adjourn</td>
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</table>
Agenda Review: October 20th, 2015

9:00am: Welcome and Day 1 Review

9:10am: Evaluating the Learning Community

9:20am: State Sharing

10:20am: Second State Team Time

11:20am: State Report Out

12:20pm: Lunch: Facilitated Final Comments and Next Steps

1:00pm: Adjourn
ASTHO LARC Immediately Postpartum Learning Community

- Ellen Pliska, MHS, CPH, Director, Family and Child Health, ASTHO

- Lisa Waddell, MD, MPH, Chief Program Officer, Community Health and Prevention, ASTHO
ASTHO LARC Immediately Postpartum (IPP) Learning Community

- Improve state capacity to improve access to LARC IPPs
  - Facilitate state-to-state sharing
  - Provide technical assistance
  - Develop state stories, tools, and a toolkit on state solutions and materials

- Partners: ACOG, AMCHP, CDC, CMS, NFPRHA, OPA
LARC IPP Learning Community Domains

- Training*
- Reimbursement and Sustainability*
- Consent*
- Stocking and Supply*
- Outreach
- Measurement, Evaluation, and Data
- Stakeholders and Partnerships
- Service Location
- Cross cutting: Policy, Leadership

*Cohort 1
Domain 1: Training

- Technical Assistance:
  - Developing and adapting provider training
  - Identifying/developing implementation tools
  - Examples of successful training at multiple levels: provider, billing/coding, pharmacy, education

- Georgia: Partnering to train urban and rural providers
- New Mexico: Working with telehealth to provide CMEs
- South Carolina: Developing LARC Inpatient A to Z Toolkit
Domain 2: Reimbursement and Sustainability

- Technical Assistance:
  - Understanding Medicaid policies and the billing/revenue process
  - Assessing reimbursement processes
  - Working with private insurance and other funding

Colorado
State sponsored legislation and new private funders for LARC

Massachusetts
Providers advocating to Medicaid to change reimbursement structure

New Mexico
MMCO coordination to educate providers that IPP LARC is reimbursable
Domain 3: Consent and Coercion

- Technical Assistance:
  - Creating guidelines regarding the timing of consent
  - Creating formal consent forms for IPP LARC
  - Confidentiality issues with private insurance

Lesson Learned: When is the best time for IPP LARC Consent

Raised issues around reproductive justice for vulnerable populations
Domain 4: Stocking and Supply

- Technical Assistance:
  - Addressing LARC device cost, purchasing Liletta
  - Pharmacist, hospital administrator role as a partner
  - Using alternate funding to address stocking and supply

South Carolina offers support to states for stocking and supply issues through outpatient strategies (specialty pharmacy and pharmacy medical benefit) and inpatient support.
Moving Forward: Year 2 Expectations

- Outreach
- Measurement, Evaluation, and Data
- Stakeholders and Partnerships
- Service Location: All
Moving Forward: Year 2 Expectations

- Virtual learning sessions: Timeline
  - Session #1: December 17th, 2015
  - Session #2: February 2016
  - Session #3: March/April 2016
  - Session #4: May 2016

- Key informant interviews
ASTHO LARC Webpage

ASTHO LARC Resources

http://www.astho.org/Programs/Maternal-and-Child-Health/Long-Acting-Reversible-Contraception-LARC/
Cohort 2 Presentations

Delaware  Indiana  Louisiana  Maryland
Delaware
Delaware – Children in Poverty

Percent of Children Under 18 Years Below the Federal Poverty Level, 2013

US Census Bureau, 2013 American Community Survey
Delaware – Number of Live Births, 2013*
(by Race, Counties and City of Wilmington)

*Preliminary data only

Division of Public Health, Health Statistics Center
*Preliminary data only
Delaware - Unintended Pregnancy

Percent of Pregnancy which were Unplanned, 2010

Unintended Pregnancies in the United States, Guttmacher Institute, 2015
Delaware – Teen Births

Five-Year Teen Birth Rate per 1000 Women Aged 15-19 Years, Delaware

Division of Public Health, Health Statistics Center

*Preliminary data only
Delaware - Interval Between Births

Number of births by Interval since Last Live Birth and Year of Birth, Delaware

*Preliminary data only

Division of Public Health, Health Statistics Center;
Excludes first-time mothers and 2+ multiple births
Delaware – Infant Mortality

Five-year Average Infant Mortality Rates by Race, DE 2007-2013

Division of Public Health, Health Statistics Center

*preliminary data
Delaware Infant Mortality

Five-Year Infant Mortality Rate, Delaware, 2009-2013
By Counties and City of Wilmington

- Sussex
- Wilmington
- New Castle
- Kent
- Delaware
- US

Division of Public Health, Health Statistics Center

*Preliminary data only
Delaware Birthing Facilities

- Christiana Care Health Services (CCHS)
- Bayhealth Medical Center
- St. Francis Hospital
- Nanticoke Memorial Hospital
- Beebe Medical Center
Delaware Medicaid Policy

Section 1.1.2.3.1

The Delaware Division of Medicaid & Medical Assistance (DMMA) implemented a fee-for-service reimbursement for Long Acting Reversible Contraceptives (LARC) in situations where provider reimbursement is a bundled rate. Historically, these sites have not included this type of contraceptive approach and therefore the bundled rate does not account for provider costs. The DMMA is actively promoting the wider use of LARC. With our claims processing of National Council Prescription Drug Program transactions, we believe this is the most efficient means of reimbursing for these services and for tracking the delivery of the LARC.

<table>
<thead>
<tr>
<th>Successes</th>
<th>Challenges</th>
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<tbody>
<tr>
<td>Leveraging the Power of Partnerships and Collaboration</td>
<td>Practice Transformation</td>
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<tr>
<td>• Delaware Division of Public Health</td>
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<td>• Delaware Medicaid and Medical Assistance</td>
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<td>• Upstream USA</td>
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<tr>
<td>• Delaware Healthy Mother and Infant Consortium</td>
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<tr>
<td>Political Will and Support</td>
<td>Communication plans or tools to roll out to stakeholders and community</td>
</tr>
<tr>
<td>• Delaware’s Plan to Improve birth intention, health outcomes, and access to the most modern, effective, reversible methods of contraception</td>
<td></td>
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<tr>
<td>• State Commitment</td>
<td></td>
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<tr>
<td>Medicaid Policy Changes</td>
<td>Addressing misperceptions and concerns by providers and the public</td>
</tr>
<tr>
<td>Enthusiasm and momentum among DE providers</td>
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</table>
Delaware - Technical Assistance Needs

- Best practices for implementing a postpartum LARC program (i.e. identifying key stakeholders to include within the hospital, conducting internal action planning, developing protocols and procedures, and systems.)

- Assist with a quality improvement model to establish protocols at the hospital

- Address misperceptions and concerns by providers (i.e. expulsion rates of IUDs and the effects of hormonal implants on breastfeeding)

- Communication plans or tools to roll out to stakeholders and community (i.e. education materials to raise awareness to consumers and providers)

- Medicaid reimbursement policies and billing/revenue processes (i.e. sample announcements, working with private payers)

- Evaluation (i.e. best practices to monitor impact and outcomes)
How have other states approached providing LARCs to minors (under age 18)? Can a minor in your state consent to a procedure to insert IUDs and/or implants?
Indiana
Indiana Birth Data

- Indiana had 83,115 births in 2013

- Indiana continues to struggle with high infant mortality rates
  - Indiana was the 7th worst state in 2011 (7.7), 11th worst state in 2012 (6.7), and the rate went back up to 2013 (7.15)

- There are currently 92 birthing hospitals in the state

- The adolescent birth rate for Indiana is estimated to be 37.3 births per 1,000.

- For all 15-17 year old women who have had an adolescent pregnancy, 17.1% have a second pregnancy within 12 months and 22.5% have another pregnancy within 18 months.

- Study on trends in LARC use among teens aged 15-19 years seeking contraceptive services showed only 1.5% in Indiana chose a LARC method (MMWR, April 10, 2015, Vol. 64, no. 13, pp363-369)
Indiana 2013 Birth Data Continued

- Perinatal Risks: 47.6%
- Congenital Malformations: 22.0%
- SUIDs: 14.0%
- All Other Causes: 15.3%
- Assaults/Other Accidents: 1.3%

Indiana N = 594
Indiana Medicaid LARC Policy

Historically, Indiana Medicaid paid for LARC devices implanted during an office visit, but included the LARC device in the overall payment for delivery services if the device was implanted in the hospital after delivery.

- Hospitals were reluctant to accept this additional cost

The Indiana Perinatal Quality Improvement Collaborative (IPQIC) Finance Committee reviewed the literature and recommended that the cost of the device inserted post-partum in the hospital be billed separately.

Effective June 1, 2015, the Indiana Health Coverage Programs (IHCP) allowed separate reimbursement for LARC devices implanted during an inpatient hospital or birthing center stay for delivery

<table>
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<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>J7300</td>
<td>Intrauterine copper contraceptive</td>
</tr>
<tr>
<td>J7301</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 13.5 mg</td>
</tr>
<tr>
<td>J7302</td>
<td>Levonorgestrel-releasing intrauterine contraceptive system, 52 mg</td>
</tr>
<tr>
<td>J7306</td>
<td>Levonorgestrel (contraceptive) implant system, including implants and supplies</td>
</tr>
<tr>
<td>J7307</td>
<td>Etonogestrel (contraceptive) implant system, including implant and supplies</td>
</tr>
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Successes, Challenges, and Recommendations Around LARC

- The reimbursement on top of the DRG is very new for Indiana Medicaid and we will need to wait to see if providers and women use this benefit.

- IPQIC Subcommittee on Preconception and Interconception Care has recommended:
  - Expanding access to post-partum LARC by developing tools for health care providers to facilitate billing and coding.
  - To increase use of LARC methods, barriers such as lack of health care provider knowledge or skills and low patient awareness should be addressed.

- IPQIC Education Committee has begun addressing the above recommendations. Plans are:
  - To develop a tool kit for providers with the latest information on use of LARC and how to bill for it.
  - To develop educational information for consumers about the LARC option and how to obtain it.
Technical Assistance Needs

- Identifying solution to coverage and implementation issues with the Indiana Medicaid reimbursement policy for LARC

- Increasing overall coverage, especially among rural and high infant mortality rate counties

- Educating physicians and patients/consumers on LARC
Questions for Other States

- What have other states used to assist medical practitioners to increase the use of LARC?

- How have other states addressed barriers to use of LARC?
  - E.g. Belief that it may interfere with breastfeeding
  - E.g. Belief that it is harmful for adolescents

- What materials have other states developed to inform women of childbearing age about the LARC options and address the above barriers?
Indiana Core Team

- **Senior Deputy:**
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- **State Health Agency Lead Contact and MCH/Title V Director:**
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- **Medicaid Representative:**
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  azerr@iu.edu

- **Provider Representative/State Champion:**
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  Department of Obstetrics and Gynecology
  Division of General Obstetrics and Gynecology
  Indiana University School of Medicine
  bbtuckere@iupui.edu
Louisiana
The State of Louisiana
Pelican State
18th State to join the USA
Ranked #1 in Personal Happiness

- Population
  - 4.65 million (2014)
    - 51% female, 63% White, 32.5% Black or African American, 4.5% Other
  - 19.1% live below FPL
- 62,913 live births to Louisiana resident mothers (2013)
- 63,085 live births occurring in Louisiana (2013)
- 49 birthing facilities (2015)
- 37.4 per 1,000 population = teen birth rate, ages 15-19 (2013)
- Approximately 70% of births are born to Mothers on Medicaid
  - Postpartum visit rate in 2012: 70% (HEDIS hybrid - administrative claims & chart review data)
    - Minimal variation when stratified by race
- 324,300 women in need of publicly funded family planning services (2013)
LARC Use in Louisiana

There’s nowhere to go but up!
(If a woman chooses, that is)

According to the Pregnancy Risk Assessment Monitoring System (PRAMS), (surveyed between 2-9 months of the post partum period in 2012)
- 20.35% report yes to “doing anything now to keep from getting pregnant”
- 25.64% report not currently wanting to use birth control
- 20.77% of those who are currently not “doing anything...” are worried about side effects from birth control
- 3% report using implant
- 13.12% report using IUD

According to the Office of Population Affairs (OPA), Family Planning Annual Report (FPAR, 2014), Title X Service Sites
- 3.58% of 15-19 year olds that visited a Title X clinic reported yes to using a LARC
- 6.49% of 20-44 year olds that visited a Title X clinic reported yes to using a LARC

According to Medicaid claims data, LARC insertions increased from nine percent (7,000) of all child-bearing aged enrollees in 2013 to 11% (10,000) in 2014.
Louisiana LARC Medicaid Postpartum Policies

- Effective June 20, 2014, hospitals began to receive an additional payment when the insertion of LARC for women newly post-partum occurred prior to discharge. The payment for the LARC will be equal to the fee on the DME fee schedule and will be in addition to the hospital’s per diem payment.

- Effective June 1, 2015, legacy Medicaid began to no longer reimburse obstetrical delivery CPT codes that include antepartum and/or postpartum care. Prenatal care billing should continue to use outpatient visit ‘evaluation and management’ CPT codes (new and established patient) modified with ‘TH’. The most appropriate ‘delivery-only’ CPT code is to be submitted for the delivery itself. The specific postpartum care CPT code may be used for billing that service when the postpartum visit occurs.
Louisiana: LARC Challenges and Successes

**Challenges**
- Provider comfort
- Provider training
- Office stocking, billing, pharmacy and medical benefits
- Patient education
- Perspective Payment System reimbursement for FQHCs and RHCs

**Successes**
- Senior level stakeholder support within LA Department of Health and Hospitals & clinical champions and partnership with Medicaid
- Medicaid policy changes
  - Addition of LARC as a Medical Benefit (prior to 2014, only Pharmacy) & creation of Take Charge Plus Family Planning SPA
  - Removal of preauthorization's for LARC in Bayou Health (MCO) and prohibition of step therapy for devices and procedures
  - Additional reimbursement for post-placental insertion prior to hospital discharge
  - Unbundling of CPT delivery codes
- Statewide Title X Provider LARC Training via UCSF Bixby Center for Global Reproductive Health
Louisiana: Technical Assistance Needs

**Technical Assistance Needs**
- Cost Analysis
- Data Analysis
- Policy Change SPA language examples
- Regional & statewide strategies to increase provider comfort and clinical education
  - OBGYN, Primary Care, Pediatricians, Family Practice
  - Linkages to providers and clients with MCOs for Pre and postnatal Care
- Tips on how to make stocking easier for providers
- Regional & statewide strategies to facilitate patient education and demand for tiered contraceptive counseling
- White bagging

*Questions? Comments? Suggestions?*

*Rebecca.Gurvich@la.gov*
Maryland
MARYLAND FACTS

- The 2014 estimate of Maryland population is about 6 million people (5,976,407) \(^1\)
- Total live births: 71,806 (2013) \(^2\)
- Birth rate: 12.1 per 1,000 population (11.6 White, 13.0 Black, 19.7 Hispanic). Compared to U.S. birth rate of 12.5 per 1,000 population (2013) \(^2\)
- Infant Mortality Rate: 6.6 per 1,000 live births (2013). Average in the U.S.: 6.0 (2012) \(^2\)
- Preliminary FY 2014 vital stats report 73,588 live births, of which 32,101 (43.6%) were covered by Medicaid \(^3\)
- There are 32 birthing hospitals in the state of MD
- Total outpatient visits with LARC placement: 538 (2012) \(^4\)
- Total Postpartum inpatient LARC Insertions: 353 (2014) \(^4\)

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\(^3\) DHMH - Office of Health Services - Division of Community Liaison and Care Coordination - Family Planning Program.

\(^4\) Health Services Cost Review Commission (HSCRC) hospital inpatient claims. (2014)
Maryland Medicaid Policy on LARC Immediately Postpartum

- The Maryland Medicaid Program recognizes office visit and preventive visits codes as family planning services when billed in conjunction with a contraceptive management code. The Program also has a Family Planning Waiver Program which provides benefits limited to contraceptive management (i.e. office/clinic visits, laboratory services, devices and methods, including voluntary permanent sterilizations. There are no pharmacy co-pays.

- The Program covers all FDA-approved contraceptive products and devices, generally identified by –A and –J codes.

- Maryland Medicaid covers all LARCs, including those placed immediately postpartum and does not require preauthorization. The Managed Care Organizations (MCO) that participate in Medicaid’s managed care program may require preauthorization.

- There was no distinction made between IPP LARCs and LARCs placed outpatient.

DHMH - Office of Health Services - Division of Community Liaison and Care Coordination - Family Planning Program
Successes in Maryland on Postpartum LARCs-DHMH

In September 2014, a transmittal went out from the Secretary of Health to all hospitals in Maryland that LARC devices and insertion procedures are reimbursable and are separate from the bundled delivery fee. The Secretary requested that all hospitals reply to the letter with a plan that should include information about whether this service is currently provided, type of LARC that is utilized, barriers to implementation, and solutions to overcome the barriers.

This initial communication allowed for first steps towards a general assessment of LARC usage in Maryland, names of potential LARC Hospital Champions, and challenges/barriers that hospitals were facing with LARC usage.

Between 11/1/2014 and 1/29/15 an evaluation of the seven birthing hospitals in Baltimore City was completed. Of the seven hospitals, three are providing IUDs and/or implants and two will be applying for the Ryan White Training Grant to obtain funds to train residents on LARC placement.

Successes in Maryland on Postpartum LARCs - Johns Hopkins

- Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center began offering postpartum LARCs around 2009 to 2010 with the assistance of a grant from an anonymous donor\(^1\).

- They recommend training sessions for those who are inserting LARCs postpartum and during Cesarean sections that can address challenges and barriers to the insertion process. They also recommend contraception counseling during the antepartum period\(^1\).

- Doctors at Hopkins have offered to give grand rounds regarding LARCS. They also have connected Hopkins nurses to other hospital nurses for LARC placement education\(^1\).

- Johns Hopkins Bayview is placing about 50 LARC devices per month. About half of these are IUD's and half are implants. Mirena is more popular than Paragard\(^2\).
  - Many of these devices come from the Ryan LARC program, which is available to sites involved in the Ryan Residency Training Programs or Family Planning Fellowships\(^2\).

1. Choo, Shelly. Meeting with faculty members from Johns Hopkins Medicine regarding DHMH transmittal on LARCs. Meeting Notes . (December 2016)
2. Raisler, Kate. Johns Hopkins Bayview, Department of Gynecology and Obstetrics. Email . (October 2015)
**Successes in Maryland on Postpartum LARCs- Sinai Hospital**

- From 2006-2011, Sinai Hospital had the highest rate of inadequate birth spacing (191.6 women per 1,000 live births) compared to all birthing hospitals in Baltimore City\(^1\).

- Residents completed a quality improvement initiative in 2015 for high-risk inpatient obstetric patients that aimed to address family planning needs, spacing, and prevent unintended pregnancies\(^2\).

  The results of the QI project were as follows:
  - They increased provider awareness of contraceptive options\(^2\).
  - Provided patients with improved contraceptive counseling \(^2\).
  - Provided access to effective and reliable long-acting contraception in the immediate postpartum period\(^2\).
  - Further data on the effects of the project are still pending.

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Challenges in Maryland around Postpartum LARCs

- Individual Hospital Concerns
  - Maternity patients are inpatient so the cost of LARCs would become a cost of care to the institution
  - Acquiring the device and the large stocking cost--would need to ensure this is worthwhile
  - Require approval and coordination with pharmacy
  - Concern about the expulsion rate
  - Lower expulsion rate with better training--nurses and docs would require this.
  - Competing Interests - Priority focus is on breastfeeding and would make it difficult to provide family planning counseling during the antepartum period
  - Inpatient Pharmacy reluctant to have Nexplanon on formulary b/c of low reimbursement concerns
  - Catholic hospital polices which do not allow contraception.

- Data collection on LARC usage in hospitals

- Providing training opportunity to clinicians that provide placement of IUD and Implants that specifically address placement in postpartum patients

- How to work with religious affiliated hospitals and options for LARC implementation

- Understanding who key stakeholders are to get involved so that the LARC policy is used effectively
Technical Assistance Needs (how can we help you?)

1. Is there a way for hospitals to bill for LARC counseling?
2. Are other hospitals units other than L&D being considered in LARC trainings, such as the emergency department clinicians?
3. The usage of LARC's postpartum are considered an off label use, although it is recommended by the CDC and ACOG. Are there specific legalities that we should to be aware of? Is there specific wording on the off label usage that should be used in the toolkit?
4. How are clinician trainings being conducted for IUD placements postpartum and cesarean? Are the education requirements the same as with interval IUD's?
5. Any guidance on creating the online toolkit, such as software used or technical issued encountered when making an online toolkit and what should be included.
6. Guidance on data collection and how to improve this for the future.
Pose 1-3 questions, challenges, or resources needed to the group for discussion.

1. How to successfully incorporate LARC initiatives in hospital policies and processes, which will involve obtaining hospital buy-in and involving key hospital staff?

2. Providing clear billing guidelines, codes, and reimbursement information

3. How to provide regular clinical trainings that addresses the nuances of IPP vs interval LARC placement and having opportunities for residents to practice under clinical supervision.
Lunch – Facilitated Peer Group Discussion

Peer Breakout Groups:

- Orange: Patient/Provider Education
- Green: Service Location
- Pink: Medicaid Reimbursement Policies and Processes
- Black: Logistical Challenges to LARC IPP Implementation Group 1
- Blue: Logistical Challenges to LARC IPP Implementation Group 2
- Yellow: Leadership and Systems
Cohort 2 Presentations

Montana

Oklahoma

Texas
Montana
Montana Medicaid LARC Policy
Montana Stats

- Montana had 12,202 births in 2014
- Medicaid pays for approximately 43% of births.
- 30 birthing hospitals
  - 10 prospective payment hospitals (PPS)
  - 17 rural critical access hospitals
  - 1 Indian Health Service hospital
  - 2 birthing centers
- Medicaid reimbursed for 892 LARCs in 2013.
Policy

- Effective January 1, 2015 Montana Medicaid unbundled the payment for LARCs at time of delivery for PPS hospitals.

- The device and the insertion are billed on a outpatient claim separate from the delivery charges.

- Claims are paid at the outpatient rates.
Challenges

• **Provider buy in**
  ▫ Only 3 providers have billed for 4 immediately post partum LARCs since January 1, 2015.

• **Provider education**
  ▫ Getting the information to providers is a problem we face with all of our Medicaid policies.

• **Member education**
  ▫ We have not done this at all as we currently do not have a method to contact our members with new information.
Questions

• What was your most successful way in obtaining provider buy in?

• How does your state do member education?

• How does your state do provider education?

• Would you change anything about how your state educated either providers or the members?
Oklahoma
Oklahoma State Profile

- Centralized State Public Health Department System
  - Oklahoma State Department of Health Central Office and 68 County Health Departments

- Oklahoma and Tulsa City County Health Departments Autonomous

- Medicaid and Mental Health Separate Agencies from Health Department

- Strong, Collaborative Public Health System and Public-Private Partnerships

- 53,225 births in Oklahoma (approximately 60% Medicaid)

- 55 birthing hospitals
## LARC Utilization Among SoonerCare (Medicaid) Members in Oklahoma

<table>
<thead>
<tr>
<th>Counts of SoonerCare Members using BC^</th>
<th>Percentage of SoonerCare Members using BC^</th>
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<tbody>
<tr>
<td>SFY 2014</td>
<td>SFY 2014</td>
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<tr>
<td>18 and Under</td>
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<tr>
<td>19 through 24</td>
<td>19 through 24</td>
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<tr>
<td>25 and Older</td>
<td>25 and Older</td>
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<tr>
<td>1,163</td>
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<td>1,323</td>
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<td>3,553</td>
<td>16.27%</td>
</tr>
<tr>
<td>3,685</td>
<td>14.72%</td>
</tr>
<tr>
<td>Pills</td>
<td>Pills</td>
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<tr>
<td>12,180</td>
<td>77.77%</td>
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<tr>
<td>13,833</td>
<td>63.34%</td>
</tr>
<tr>
<td>15,071</td>
<td>60.19%</td>
</tr>
<tr>
<td>Sterilization</td>
<td>Sterilization</td>
</tr>
<tr>
<td>-</td>
<td>0.00%</td>
</tr>
<tr>
<td>483</td>
<td>2.21%</td>
</tr>
<tr>
<td>1,922</td>
<td>7.68%</td>
</tr>
<tr>
<td>Other**</td>
<td>Other**</td>
</tr>
<tr>
<td>4,729</td>
<td>30.19%</td>
</tr>
<tr>
<td>8,298</td>
<td>38.00%</td>
</tr>
<tr>
<td>7,967</td>
<td>31.82%</td>
</tr>
</tbody>
</table>

Compiled by Reporting and statistics and is valid as of 10/22/2014.

Members are females between the ages of 11 and 55 with paid claims for birth control products and services during the SFY indicated.

^Members may use multiple forms of birth control in a year resulting in a percentage greater than 100% or greater than the overall total.

*LARC numbers consist of counts of both implants and IUD utilization.

**Other indicates the use of contraceptive patches, rings, shots, condoms, spermicides, and barrier methods such as diaphragms to get a full count of members utilizing birth control options.
LARC Utilization for Oklahoma State Department of Health County Health Department Family Planning Clients

LARCs Utilized by All Female Clients in 2014

<table>
<thead>
<tr>
<th>LARC Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD/IUS</td>
<td>2,581</td>
<td>5.2%</td>
</tr>
<tr>
<td>Nexplanon Implant</td>
<td>2,956</td>
<td>6.0%</td>
</tr>
<tr>
<td>Depo Hormonal Injection</td>
<td>9,552</td>
<td>19.2%</td>
</tr>
<tr>
<td>Ring</td>
<td>1,678</td>
<td>3.4%</td>
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</tbody>
</table>

LARCS Utilized by Adolescent Female Clients in 2014

<table>
<thead>
<tr>
<th>LARC Type</th>
<th>&lt;17 (Number)</th>
<th>&lt;17 (Percentage)</th>
<th>18-19 (Number)</th>
<th>18-19 (Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD/IUS</td>
<td>30</td>
<td>.5%</td>
<td>109</td>
<td>1.7%</td>
</tr>
<tr>
<td>Nexplanon Implant</td>
<td>537</td>
<td>8.7%</td>
<td>470</td>
<td>7.5%</td>
</tr>
<tr>
<td>Depo Hormonal Injection</td>
<td>1,906</td>
<td>31.0%</td>
<td>1,277</td>
<td>20.3%</td>
</tr>
<tr>
<td>Ring</td>
<td>129</td>
<td>2.1%</td>
<td>240</td>
<td>3.8%</td>
</tr>
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</table>
Oklahoma Medicaid Policy on Long Acting Reversible Contraception

- Until September 2014, LARC was included in the bundled payment for pregnancy and birthing services.

- Providers asked for change, telling the Oklahoma Health Care Authority (OHCA) that inserting LARC immediately post partum would be a great tool to reduce teenage pregnancy.

- March-June 2014: OHCA Medical Advisory Committee recommends, Board approves, and Governor signs change to pay for LARC IPP separately from bundled rate.

- September 2014: New LARC policy goes into effect.
Challenges in Oklahoma: Buy-in, Coordination, Consistency, Supply and Demand

- Communicating new policies or convincing providers to take advantage of the new policy.

- Some providers are unable to provide LARC-IPP due to their hospitals’ policies, so patients will be referred elsewhere for the LARC if they request the service, often to County Health Departments (CHDs) that have a limited supply of LARC due to rising costs and budgetary constraints.

- The largest commercial payers in Oklahoma still pay for LARC-IPP in a bundled rate. Lack of consistency between Medicaid policy and Commercial payer policy can confuse providers and create barrier to use.
Successes in Oklahoma: Policy, Promotion, Demand and Teen Births

- Oklahoma Health Care Authority (Medicaid) LARC-IPP Policy

- Promotional efforts to present LARCs as most effective method in easy to understand manner by CHD personnel to clients has been successful

- Demand and preference for LARCs in Oklahoma CHDs has significantly increased

- LARC usage by teens is increasing as teen births have been decreasing
Technical Assistance Needs

- Addressing implementation barriers with commercial payers

- Strategies for effectively communicating policies to providers to ensure buy-in and widespread, consistent utilization

- Strategies for the effective use of data to drive utilization, study effects, and target areas of greater need.
Questions?

- How have other states worked with commercial providers to change their LARC-IPP policies and share data?
  - What were biggest challenges and factors in success?

- Were any particular communication or marketing strategies used to increase use of LARC-IPP?

- How have states used data to drive utilization?
Texas
Texas is experiencing substantial population growth

- Between 2000 and 2014, Texas added 1.8 million more residents than any other state and grew by 7.2%, compared to 3.3% growth for the entire country
- In 2014, 42% of women (5.8 million) were of childbearing age (15-44)
- In 2014, 75% of women 18-64 years (6.3 million) had health insurance coverage
- Approximately 3.4 million women in Texas are below 200% of the Federal Poverty Level (FPL)

- Approximately 53% of all Texas births (207,000) were paid by Medicaid in FY 2013
- Approximately 6.9% of Texas Medicaid and Texas Women’s Health Program (TWHP) clients receiving contraception (37,260) utilized LARC in FY 2014
TEXAS – LARC Immediate Postpartum (IPP) Policy

- Under current Texas Medicaid policy, the cost of a LARC device during an inpatient stay for delivery is considered part of the facility’s diagnosis related group (DRG) payment and is not separately reimbursed.

- Effective January 1, 2016, hospitals may receive reimbursement for LARC devices in addition to the hospital DRG payment when a LARC device is inserted immediately postpartum.

- The hospital provider will be required to submit an outpatient claim with the appropriate procedure code for the LARC device in addition to the inpatient claim for the delivery services.
Texas – LARC Immediate Postpartum (IPP) Policy

Hospital providers that also contract with the state-funded Family Planning Program may receive reimbursement for a LARC device inserted immediately postpartum for Emergency Medicaid clients:

- Effective September 1, 2014, “wrap-around” reimbursement was added for LARC devices for Emergency Medicaid clients also eligible for the Family Planning Program at the time of delivery.
- The contractor is responsible for developing a process to determine Family Planning Program eligibility.
- To receive Family Planning Program reimbursement, contractors must file a separate Family Planning Program claim with the appropriate procedure code for the LARC device.
TEXAS – LARC Policy Successes

- Effective August 1, 2014, Mirena and Skyla were added to the Medicaid and TWHP formularies, allowing providers the option to prescribe and obtain a limited number of LARC devices from specialty pharmacies
  - Texas currently is working to add ParaGard, Nexplanon, and Liletta to the Medicaid and TWHP formularies
  - Providers may choose to receive reimbursement for LARC through the “buy-and-bill” method or through the pharmacy option
- Effective January 1, 2016, FQHCs may receive reimbursement for LARC devices in addition to the FQHC encounter payment
Medicaid managed care organizations (MCOs) are not required to pay providers according to the fee-for-service fee schedule

- A hospital or FQHC may not be reimbursed the same amount for the cost of a LARC device under the Medicaid managed care model as they would under the fee-for-service model
- Prior to implementation of policy changes, Texas is heavily engaging the Medicaid MCOs and professional associations representing providers to discuss LARC coverage and provide clear direction to MCOs and providers
TEXAS – Technical Assistance Needs

- Dispelling LARC myths
- Developing physician champions
- Engaging pediatricians, family practitioners, and community health workers
- Developing a postpartum insertion protocol for providers
TEXAS – Questions, Challenges, and Resources Needed

- What are other states doing to ensure that Medicaid MCOs are effectively reimbursing providers for IPP LARC?
- How are other states working with providers to dispel LARC myths?
- How are other states working with women of childbearing age to dispel LARC myths?
- What are other states doing to effectively educate and outreach to special populations (i.e., adolescents/young women, rural/urban women, racial/ethnic minorities)?
Objective: Each peer group will reflect on state presentations – lessons learned and potential opportunities for partnership to prepare for facilitated discussion
State Team Time/Discussion (All States)

- Teams will discuss current policies and challenges, identify opportunities/challenges for implementation LARC IPP, and goals for the next year.
Facilitated Discussion: Synthesis of Initial State Team Discussions and Existing Models and Opportunities for Replicating

- How are state partners working together?

- What are best practices for overcoming barriers/gaps and setting priorities to improving access for LARC immediately postpartum?

- What programs or policies are currently in place?

- What opportunities exist to work together?
Welcome Back!
Day 1: Themes

- Stocking and Supply
- Reimbursement Issues
- Communication
  - Provider education
  - Consumer education
- Provider Training
- Informed Consent
- Policy Sensitivities
Welcome and Introductions: Day 2

- Kristin Rankin, PhD, Division of Epidemiology and Biostatistics, Center of Excellence in Maternal and Child Health, School of Public Health, University of Illinois at Chicago

- Carla DeSisto, MPH, PhD student, Maternal and Child Health Epidemiology, School of Public Health, University of Illinois at Chicago
Evaluating the Implementation of IPP LARC in ASTHO Learning Community States

Kristin Rankin, PhD
Assistant Professor
Division of Epidemiology and Biostatistics
Center of Excellence in Maternal and Child Health
School of Public Health
University of Illinois at Chicago
Introductions

**Kristin Rankin, PhD**
- UIC SPH Faculty member, MCH Epidemiology
- Expertise and current research in:
  - postpartum care and contraception
  - Medicaid claims analysis
- Ongoing training and technical assistance activities with MCH epidemiologists in state, tribal and local health departments
- Interest in using Implementation Science frameworks and methods to study the roll-out of IPP LARC in Learning Community States

**Carla DeSisto, MPH**
- PhD student in MCH Epidemiology at UIC
- Experience with qualitative and quantitative studies
- Previously an ORISE Epidemiology fellow at the CDC El Paso Quarantine Station – worked closely with US border states
Our goals

- Work collaboratively with ASTHO, CDC, State Teams, and other partners to generate information to:
  - Optimize Learning Community activities
  - Document implementation activities, barriers and facilitators in Learning Community states
  - Disseminate lessons learned to inform continuing efforts to implement IPP LARC in Learning Community and other states
- Support state teams in using Medicaid claims data to monitor IPP LARC uptake in their states
Planned Evaluation Activities

- Participation and Observation at Learning Community Meetings
  - Kick-off meeting
  - Web-based Sharing and Learning Sessions

- Key Informant Interviews
  - Cohort 2 (Nov-Dec 2015)
  - Cohort 1 (Jan 2016)

- Team Self-Evaluation Development
  - Cohorts 1 & 2 (~Spring/Summer 2016)
Evaluation Framework

- Implementation activities, barriers and facilitators organized into eight key domains

<table>
<thead>
<tr>
<th>8 Domains</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Stocking and supply</td>
<td>Service locations</td>
</tr>
<tr>
<td>Training</td>
<td>Stakeholder partnerships</td>
</tr>
<tr>
<td>Pay streams</td>
<td>Outreach</td>
</tr>
<tr>
<td>Consent</td>
<td>Data and surveillance</td>
</tr>
</tbody>
</table>
Example: Cohort 2 Key Informant Interviews

Areas of Focus (across 8 domains):

- Structure of State Medicaid Policy
- Current and Planned Implementation Efforts
- Facilitators in your state or agencies
- Barriers and challenges faced by your state teams
- Innovative strategies for overcoming challenges
- Technical assistance needs
Planned Evaluation Products

- Written summaries and full reports from key informant interviews and self-evaluation
- Contribution to the documentation of implementation strategies employed across states
- Other evaluation products that would support your efforts?
Thank You!

Kristin Rankin, PhD

krankin@uic.edu
Cohort 1 Presentations

South Carolina

New Mexico

Massachusetts

Iowa

Georgia

Colorado
South Carolina
South Carolina Birth Outcomes Initiative: LARC Inpatient Insertion Update

October 19-20, 2015
BZ Giese, BSN, RN
Amy Picklesimer, MD, MFM
Stephanie Derr, MSN, RN
South Carolina BOI: A National Leader

ENHANCED MEDICAID COVERAGE FOR POSTPARTUM BIRTH CONTROL

2012 vs 2015

Source: U-M Health System study

Health System University of Michigan

astho tm
South Carolina BOI Success: LARC Study Results

Objective:

- In this study, we compare implant continuation rates at 6 and 12 months post-insertion for women undergoing immediate inpatient insertion after delivery (inpatient) to women having routine outpatient implant insertion six weeks post-partum or during a routine gynecologic visit (outpatient).
Study Design:

- Retrospective cohort study using review of medical records for all women receiving the etonogestrel implant between July 1, 2007 and December 31, 2013 at a large tertiary care hospital in South Carolina.

- Demographic differences, continuation rates at 6 and 12 months, and reasons for early removal were compared using two-tailed independent sample t-tests for continuous variables and χ² or Fisher’s exact test for categorical variables.

- Crude and multiple logistic regression modeling were performed.
Results:

- Continuation rates were assessed at 6 months (n=776) and 12 months (n=518) after insertion. There were no differences in continuation rates at 6 months between inpatient insertion (n=330, 96.5%) and outpatient insertion (n=412, 94.9%).
- At 12 months, continuation rates were higher for inpatient (n=129, 92.8%) compared to outpatient (n=327, 86.2%), (p=0.043).
- After controlling for differences between groups, women with inpatient insertion were less likely to have the implant removed at 12 months than were women with outpatient insertion (OR=0.43, 95% CI [0.20,0.97], p=0.041).
- The most commonly stated reason for removal among women in both groups was abnormal bleeding.
Conclusion:

- Insertion of the etonogestrel implant during the immediate post-partum period, prior to discharge from the hospital is well tolerated by women and is associated with high continuation rates at both 6 and 12 months after insertion.
Since FY13 to FY15, we have had a 110% increase for inpatient insertion of LARCs.

“This is preliminary data and may not currently reflect all of the claims. As such, this data is an under-representation of actual clinical practice.”
SCBOI Success LARC (cont.)

- 16% Inpatient
- 84% Outpatient
SCBOI LARC Goals

- Finalize and Disseminate toolkit: “LARCs Inpatient A to Z.”
- Increase number of hospitals participating in inpatient insertion.
- Develop a process for immediate LARC PP reimbursement for women without a payor source (DHEC sterilization contract amendment Title X dollars).
**SCBOI LARC LESSONS LEARNED**

- Education about the policy and reimbursement is crucial to success
  - Focus areas should include the hospital pharmacy and **claims department**, managed care leaders if applicable in your state, hospital administration

- Don’t underestimate the power of your Clinical Champion to be a major catalyst to move this policy forward in the hospital
THANK YOU!

BZ Giese, BSN, RN- GieseM@scdhhs.gov
Amy Picklesimer, MD, MFM- APicklesimer@ghs.org
Stephanie Derr, MSN, RN- derrsr@dhec.sc.gov
New Mexico
New Mexico LARC Learning Community

NM Department of Health
University of New Mexico
New Mexico Perinatal Collaborative
Teen Birth Rate
Colorado, New Mexico, and the United States, 2004-2013

Birth rate per 1,000 females ages 15-19

Year


Colorado New Mexico US

source: http://www.cdc.gov/nchs
Action items ASTHO 2014

- Create LARC project in NM Perinatal collaborative
- Convene Medicaid, MCOs, DOH and UNM hospital finance
  - Delineate pathway to PP LARC reimbursement
  - Resolve billing issues
  - Create toolkit
- Track PP LARC insertions paid by Medicaid
- Explore “white bagging”
- Engage with IHS
Successes

- Perinatal Collaborative solidified
  - LARC added as project
  - Project has multi-stakeholder workgroup
    - DOH
    - UNM
    - Medicaid
- UNM places 30-40 PP LARC per month
  - 60% are Medicaid
  - 40% are from Ryan LARC grant
  - Standardized protocol and didactic and hands-on training
Challenges

- Billing issues not resolved
  - Hospital
    - Not a priority
  - Medicaid
    - Personnel changes
  - MCOs
    - The enemy?
- No other hospitals are placing PP LARC
- Perinatal Collaborative needs more robust funding!
The meeting that took a year to schedule…

- Billing PP LARC on a 1500 (as per HSD guidance) instead of the UB
- MCOs are denying PP LARC
  - System is set up to pay these on a UB instead of a 1500 or 2) denying based on bundling
- Meet with MCOs each month - give them a short presentation on this
- Need state help: shouldn’t have denied these to begin with — so they shouldn’t use “timely filing” as a reason not to back-pay. In that case, will ask for Medicaid/HSD help
- PFS to send each of the MCOs the circular/education and give 2 weeks for plan or resolution
- Complete review of charges/collections
- If MCOs insist on lack of payment for “timely filing” escalate to Medicaid/HSD
- Ask Medicaid for targeted education with MCOs at their meetings
Plans

• State level DOH pregnancy prevention initiative
  • Reduce teen birth & abortion rates by 50%
  • Reduce public costs by $36.4 million/annum
• Seek private foundation funding for Perinatal Collaborative LARC project
• Re-explore white-bagging
Create toolkit
Take it on the road
Massachusetts
Massachusetts: Successes

- Engaging providers
  - MDPH contacted a number of providers at several different delivery hospitals to engage them in this effort
  - Brought together new collaborators in different ways
  - Elucidated the challenges that providers were facing
    - Focused primarily on payment

- Mobilizing providers
  - Provider-initiated letter to the Assistant Secretary for MassHealth
    -Raised the issue of payment to a high level
    - Encouraged engagement and collaboration among the providers
Massachusetts: Successes

- Significant MassHealth investment in studying the impact of postpartum LARC and alternative payment methodologies
  - Conducted an environmental scan of other states that reimburse for LARC separately, including teen pregnancy and birth rates
  - Conducted focus groups of providers and hospital administrators
  - Worked with pharmacy program to better understand related pharmacy issues: abandoned unit rates (IUDs ordered with no corresponding insertion code) and how to address this issue
  - Developed cost projections and estimates for leadership to better quantify the impact of changing the payment methodology
  - MDPH supported stakeholder engagement and information-sharing regarding hospital estimates of volume and need

- Obtained tentative approval to explore different payment methodologies
Massachusetts: Lessons Learned

- **New pricing methodology**
  - On October 1, 2014, Massachusetts Medicaid (MassHealth) adopted the APR/DRG (All Patient Refined/Diagnosis Related Group) and APAD (Adjudicated Payment Amount per Discharge) pricing methodology.
  - Analysis showed that inpatient hospital LARC insertion was treated as an ancillary service and thus did not impact the weights assigned or the payment calculation.

- **Provider and Hospital administrator focus groups were conducted**
  - Providers were highly motivated to provide inpatient LARCs, usually those with a physician champion or a Ryan program
    - Brown bagging
    - White bagging
  - Providers were directed to provide outpatient insertions. Inpatient insertion barriers included:
    - Inpatient pharmacy not carrying the devices
    - Unofficial hospital policy involved limits on number of units that can be used
    - Administrative reprimand
Massachusetts: Goals

- **Increase knowledge of and access to postpartum LARC**
  - Leverage revised ACOG guidance that includes immediate postpartum LARC as a best practice
  - Work with local and national ACOG to disseminate this new guidance

- **Better understand commercial payer policies & reimbursement**

- **Better understand other needs**
  - The conversation has been focused on payment which may be masking other needs:
    - Provider training
    - Provider preferences for inserting LARC
    - Clinic same day insertion protocols
    - Provider understanding of existing payment structures
    - Access to the devices
    - Member education and choice
Iowa
Successes in Iowa

- Unbundling of immediate post-partum LARC insertion
  - Effective March 1, 2014

- Developed evaluation plan
  - Harvard practicum – January 2015

- Obtained Medicaid claims data to assess benefit uptake
  - Provisional results – unlinked file
    - Less than 1% among women ages 15-44
Work with providers, hospitals, and health plans

- Developed sample policies
- Billing support
  - University of Iowa Hospitals and Clinics
  - Broadlawns Hospital
- Technical support and education to physicians and nurse managers
  - St. Luke’s (Cedar Rapids)
  - Methodist West, Iowa Lutheran, Iowa Methodist Medical Center (Des Moines)
  - Partnered with Meridian Health Plan (IA, IL, MI)
- Spencer Hospital (Level 1)
- Siouxland Medical Education Foundation Program
  - Family Practice Residency Program
Lessons learned

The Informational Letter is just the beginning

Lots of moving parts, partners, and unintended consequences

- Need to consider at what point in prenatal care a woman will be offered immediate PP LARC – when does she consent?
- Concern by OBs for PP HEDIS measure – if a woman gets an immediate PP LARC, will she attend PP visit?
- Concern by family planning providers – if a woman gets an immediate PP LARC, will she seek services at a FP clinic?
- 340B drugs – intended for outpatient services. Hospital reluctant to purchase LARCS since service occurs in the inpatient setting
Goals for next year

- Continue to work with birthing hospitals
- Engage new MCO medical directors
  - Support initiative
  - Support and facilitate surveillance of benefit uptake
- Develop business case for immediate PP LARC among 3-day emergency Medicaid coverage
  - 3-day emergency typically serves non-citizens
- Continue to try and meet with private insurer
  - Wellmark – 80% of all non-Medicaid
  - Verbally supportive – yet to agree to meet
- Link Medicaid paid claims to BC to explore maternal factors related to immediate PP LARC
- Examine Medicaid paid claims to determine providers and provider types who provide immediate PP LARC
Georgia
Georgia - Successes

What have been 1-2 successes for your state over the past year of the LARC Learning Community?

1. Provider training

2. Incorporating IPP LARCs into our perinatal quality collaborative (GaPQC)
Georgia – Lessons Learned

What have been 1-2 lessons learned for your state over the past year of the LARC Learning Community?

1. You’ve seen one birthing hospital, you’ve seen one birthing hospital.

2. Just because you have all the pieces in place, doesn’t mean success. Need continuous quality improvement to support implementation.
Georgia - Future Goals

What are 1-2 goals for your state over the next year of the LARC Learning Community?

1. Continue the GaPQC work and engage more hospitals in the process.

2. Begin to measure increased uptake of the immediate postpartum LARC practice.
Colorado
Colorado

Larry Wolk, Director and Chief Medical Officer
Elizabeth Whitley, Prevention Services Director
Greta Klingler, Family Planning Supervisor

Melanie Reece, Benefits & Contract Performance Specialist
Colorado Highlights from 2014-2015

- Just 511 repeat teen births in 2014 (down from 1,317 in 2007)
  - PP LARC use among teen moms is over 50%

- 25% of all post partum women are using LARC

- 42% of Colorado women 18-44 using birth control are using LARC

- 14 local foundations investing in LARC work in Colorado

- State sponsored legislation to support LARC
Colorado Successes

- Strengthened collaboration between Department of Public Health & Environment and Department of Health Care Policy and Financing
  - IPP LARC insertion payment
  - RHC carve out

- Growing interest in expanding access to IPP LARC around the state

- Continued spotlight on LARC

- New funders, providers and community partners interested in LARC

- Contraceptive quality measures being added within Accountable Care Collaborative
Colorado Lessons Learned

- Original payment methodology for covering IPP LARC wasn’t working as anticipated
- Need to analyze the data around IPP LARC Medicaid Payments
- Remaining need for provider and administrative training
- Champions are key
- Sharing data and successes are key to forward momentum
Colorado Goals

- Improve IPP LARC Medicaid payments
- Train more providers to do IPP LARC insertions
- State funding for LARC
- Provider training summit in June
- Continue to work on billing and coding for LARC (IPP and otherwise)
Cohort 1 and 2 State Teams

- Identify 1-3 actions state teams can take immediately and medium term to increase access to LARC immediately postpartum.

- Identify 1-3 actions ASTHO can take immediately and over the medium term to support states in this work.

- Identify 1-3 actions partners and evaluators can take immediately and over the medium term to support states in this work.

- What partnerships are missing?
Second State Team Time/Discussion

- Identify 1-3 actions state teams can take immediately and medium term to increase access to LARC immediately postpartum.

- Identify 1-3 actions ASTHO can take immediately and over the medium term to support states in this work.

- Identify 1-3 actions partners and evaluators can take immediately and over the medium term to support states in this work.

- What partnerships are missing?
Cohort 1 and Cohort 2 Teams

- Team 1: Delaware and South Carolina
- Team 2: Maryland and Georgia
- Team 3: Indiana, New Mexico, Montana
- Team 4: Louisiana and Massachusetts
- Team 5: Oklahoma and Colorado
- Team 6: Texas and Iowa
State Report Out

- Highlight one action step you will take
Lunch: Facilitated Final Comments and Next Steps

- What has been accomplished over the last year and what can the learning community expect over year 2?
Virtual Learning Session #1

Save-the-Date: Learning Session #1
December 17th, 2015
2:00PM – 4:00PM ET
Thank You!

- Please remember to fill our your meeting evaluation form (located in your folder) and return to an ASTHO Staff Member.

- Reimbursement forms are included in your folder (we will email you a copy as well).